

HIPAA OVERVIEW

WHAT IS IT

The Health Insurance Portability and Accountability Act (HIPAA) will change certain aspects of the way health care is administered over the next few years. President Clinton signed the Archer/Kassebaum-Kennedy Health Insurance Portability and Accountability Act on August 21, 1996. HIPAA is designed to expand health coverage by improving the portability and continuity of health insurance coverage in group and individual markets; to combat waste in health care delivery; to promote the use of medical savings accounts; to improve access to long-term care services and coverage; and to simplify the administration of health insurance. Within this context, HIPAA includes a provision called Administrative Simplification, which is intended to improve the efficiency and effectiveness of the health care system by encouraging the development of standards for the electronic transmission of certain health information. HIPAA also establishes privacy and security standards related to health information.

NATIONAL STANDARDS

Through the adoption of national standards, the health care industry can realize cost savings by reducing administrative duplication. These standards are developed by processes delineated in the HIPAA legislation and are established by the publication of a "rule" in the Federal Register. There are currently eight proposed rules within the HIPAA legislation, more will likely follow in the next few years.

Once each rule is published in the Federal Register, following a 60 day Congressional concurrence period, organizations have 24 months to become compliant. Public agencies are not exempt from HIPAA and must comply with the law which impacts "covered entities," described by HIPAA as providers, clearinghouses and health plans. Programs within State Agencies that fund health care services, under HIPAA, are usually considered health plans.

The "Transaction and Code Sets" rule, published in August 2000, was the first rule published. Health care organizations have until October 17, 2002 to comply with its requirements. The Transaction and Code Sets rule will apply to those "covered entities" that perform the following business functions:

- ?? send or receive health care claims
- ?? pay health care services
- ?? send or receive eligibility inquiries
- ?? conduct provider referrals and service authorizations
- ?? perform health plan enrollment
- ?? perform coordination of benefits activities

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The second rule is the Privacy Rule published in December 2000. Health care organizations may have until February 20, 2003 to comply with its provisions. The Privacy Rule applies requirements for viewing, handling and storing patient identifiable health care information that is written, electronic, faxed, verbal and when present on a monitor screen. It will require a review and possible revision of many information policies, procedures and practices.

WHO MIGHT BE IMPACTED

All public health and behavioral health programs will be impacted. Departments and program areas may be impacted to varying degrees that will depend upon the types of services they provide and their current administrative processes.

Any program area would almost certainly be impacted if it:

- *receives, submits or pays health care claims,*
- *is involved in plan enrollment or benefits, or*
- *receives, distributes or retains patient health care data.*

Any program may be impacted if it:

- *receives or submits medical information from / to a business partner,*
- *utilizes information collected from a provider working in a HIPAA compliant environment,*
- *uses detailed or summary medical information from other entities, or*
- *generates reports from medically related information.*

Health care and medical data will have new data code set standards and formats. There are also new rules for the receiving, distributing and retaining of that data. Any program involved in any of the service delivery, collection, storage or distribution processes may be impacted. These programs need to review their programs and processes for potential implications and actions to address the issues. A major factor is the communication and coordination with your business partners.

HIPAA will eliminate the use of "local codes", codes that are not within the standard code sets. These code sets include medical procedure, health care service, mental health services and administrative reporting codes. Many such codes are utilized to support key programs within county and provider processes. Program areas will need to look for new ways to track and report services currently supported by non-standard codes. If alternative reporting solutions are not developed, a county's ability to administratively support some of the programs may be negatively impacted. All county and state programs that use local codes need to consider options for compliance. This may cause additional costs for impacted programs and requires coordination with business partners.

The Privacy Rule deals with health information that is individually identifiable. While we all have security and privacy policies in place, the HIPAA standards may be more stringent and may require extensive documentation that is not currently in place today. Programs need to review their policies to ensure compliance. Most certainly every area will need to provide education and

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training to every person (employee, contractor, and temporary help) that potentially has access to health care data. By April 14, 2003, all organizations need to be compliant with the Privacy Rule.

Other examples of potential impacts to consider include:

- Our business partners may use HIPAA compliant data collection processes that have limited coding sets, new field attributes and new definitions from current practices. These data collection processes may not provide enough specificity to meet current program objectives. For example, with issues of program access, race – ethnicity codes in the standard do not use the range currently in many programs. Also, cross walks for a number of different codes may be needed.
- There may be additional costs to collect and report non-HIPAA compliant data.
- The Provider Taxonomy proposed may not uniquely break out the various types of providers currently defined. Provider reports may be impacted.
- Provider numbers will be established at a national level and may not resemble the currently used numbers. Having access to currently valid numbers may be important in service delivery, edits and audits.
- Access to reports may need to be limited where a single person may be identified as the only person in a population group.
- Access and storage of data and records may need to have certain policies and procedures in place to ensure clients have the needed information access, right to note modifications and access to a history of data releases.
- Data transmission with business partners may require additional processes. Contract like language may be needed to document that business partners apply HIPAA compliant processes. Encryption and authentication processes may be needed when data is moved between business partners.
- Periodic audits of security, privacy and business practices may be needed to document that reasonable processes and procedures have been initiated to meet federal standards and minimize liabilities.
- A common infrastructure may be needed to minimize the impact of data transmission and access to provider numbers from the national processes.
- Similar entities may wish to adopt similar policies and procedures to ensure consistent applications of the federal standards.
- Changes to policies, Welfare and Institutions Codes, and legislation may be needed to support revised data collection, reporting and sharing processes and procedures.
- It may be difficult to find knowledgeable resources and contractors as more entities begin their HIPAA projects.
- Programs that operate a health plan for employees or constituents have potential impacts.
- Programs that use provider numbers, diagnosis codes, drug codes, local codes, health plan codes, or pass data to business partners may be impacted. Information access may be more restricted than our present practices. This may also require new computerized access controls.

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WHAT NEEDS TO BE DONE

It is important for programs that might be impacted to take steps to address the potential problems. There is a critical Federal timeline for implementation that our business partners and providers will be following. If our programs are in a similar timeline then we may impact service delivery. The first critical implementation date is October 16, 2002. Possible HIPAA Project steps might include:

- 1) **Project Initiation** (also called Awareness) needs to be established with executive level sanctioning of the efforts. Awareness can be established in a variety of ways: bringing in specialists in industry, attending conferences, reviewing the federal rules and reading credible literature. This step will also help identify the main issues the program may have to address and to create an initial Project Plan and tasks to establish compliance. In this step it is important to establish a Project Leader and Workgroup for the program. In this first step, organizations need to begin participation in the Statewide HIPAA Workgroup and Sub-Workgroup to help coordinate and communicate issues and resolutions.
- 2) Conduct an **Initial Assessment** (also called an Inventory) to establish which programs and functions are impacted. This may require training staff and interactions with your business partners. This step will also identify **External Interfaces** that you will need to interact with as you implement any changes.
- 3) A **Project Plan** is established from the tasks initially identified for achieving compliance. The Plan will identify the main tasks and milestones for achieving compliance, designate staff for each task and establish dates for task completion. The Plan becomes a tool for monitoring progress and addressing issues as your project proceeds. The Plan also helps establish a detailed resource and cost estimate for the project. A more detailed Project Plan and resource - cost estimate can be established after the Gap Analysis is completed. Project Plans need to evolve as the project and resources change.
- 4) A **Detailed Assessment** (also called a Gap Analysis or Impact Assessment) will need to be done on the programs and functions that need to have changes. The Gap Analysis looks at the gaps between the current process and procedures compared to the Federal HIPAA rules. It will also investigate the options and desired tasks needed for achieving compliance to the rules.
- 5) **Implementation** (also called Remediation) is the final step. It involves making the changes to processes and procedures, revising user instructions, training staff, testing all changes, testing with your business partners, having a coordinated implementation process, and monitoring the new production processes.

Variations of these steps may be needed for different organizations depending on the extent of changes and number of business partners involved. Critical throughout the process is top management involvement, monitoring progress toward goals, and communication and coordination with our business partners. With HIPAA being a series of Federal Rules being released and revised at periodic points, several of the above steps may need to be repeated as the rules change.

In some organizations, additional resources may not be available and are limited to those in the program area. Each entity is required to take steps to address their issues. One approach is to work with your business partners to minimize the discovery processes and to jointly address and resolve issues. Opportunities to work with business partners can be established through the national forums, occupational organizations, local or state workgroups, and workgroups within your own entity.

HIPAA COORDINATION WORKGROUP

The interdependence between state departments, counties, providers and program areas that perform health related service delivery or use health information makes it vital that we approach HIPAA with a unified voice and common methodology. There are many critical issues that are still outstanding and we need to present its views consistently at both a local and a national level. In addition, with over 90,000 providers throughout California, it is imperative that we perform outreach, education and training in a manner that is efficient and well coordinated. Further, requests for resources must be coordinated and overall progress on implementation should be monitored and coordinated so issues can be addressed quickly.

With this in mind, a California Health and Human Services (CHHS) Agency Workgroup has been established to coordinate HIPAA compliance activities on an Agency-wide basis. The group has been meeting for approximately 6 months and has focused on awareness, tracking implementation, and getting resources that will be necessary to complete this work. Because of the need to coordinate and review HIPAA implementation, this workgroup is designated as the primary vehicle to move forward with HIPAA compliance for the CHHS Agency. It is preferred that several representatives from each of county association, like Welfare Directors or Mental Health Directors, participate in the meetings and various topic area sub-workgroups. It is critical that county issues are recognized, communication and coordination achieved, and a California voice be heard in national forums. For information on HIPAA and the Agency Workgroup, please call Ken McKinstry, at (916) 654-2466 or Kmckinst@dmhhq.state.ca.us.

ACTION IS NEEDED NOW

Action is needed now to implement HIPAA in the federal timelines. Important dates occur as soon as July 2001. Counties may need to form workgroups to raise awareness, assess impacts, implement changes, address issues and coordinate with business partners as their programs, processes and procedures change. *It is critical that impacted county programs take steps to address the issues.*